



Adult Health History Form

Welcome to our office! In order for us to provide you with the best possible treatment, we would like you to provide us with the following information. Thank you!

PATIENT INFORMATION

Name _____ Nickname _____ Sex _____ Birth Date _____
Address _____ Home Phone _____ Cell Phone _____
City _____ State _____ Zip _____ Employer _____
Work Phone _____ Email address: _____

At which phone number should messages be left? _____

Whom may we thank for referring you to our office?

() Family Dentist () Relative () Friend/Neighbor () Other: _____

Name: _____

The following information is required for insurance purposes:

FINANCIAL INFORMATION

Who is responsible for payment? _____

Does the responsible party have orthodontic insurance? () Yes () No

IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insurance company _____ Address _____

Subscriber's Name _____ Relationship to patient _____

Social Security Number _____ Birth Date _____

Is there secondary insurance? () Yes () No

Name of insurance company _____ Address _____

Subscriber's Name _____ Relationship to patient _____

Social Security Number _____ Birth Date _____

Please complete medical & dental information on the following page.

HEALTH HISTORY

DATE _____

Dentist's Name _____

Date of Last Visit _____

Physician's Name _____

Date of Last Visit _____

Place a mark on "Yes" or "No" to indicate if you have any of the following:

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____ Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of feet or ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or Bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Women: Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Due Date _____			
		Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

- Does the patient experience any difficulty chewing or swallowing food? Yes No
- Has the patient had any injuries involving the teeth or jaws? Yes No
If yes, please explain: _____
- Does the patient experience any clicking of jaw pain when opening or closing the mouth? Yes No
If yes, please explain: _____
- Is the patient a mouth breather? Yes No
- Is the patient a snorer? Yes No
- Does/did the patient have any thumb or finger-sucking habits? Yes No
Any other habits? _____ To what age? _____
- Has the patient had a previous orthodontic consult or treatment? Yes No
If yes, please explain: _____
- Do other family members have a similar problem? Yes No
- Main reason for seeking orthodontic treatment: Function Appearance Referred by dentist
Explain if necessary: _____
- If referred by your family dentist, please describe his or her concerns as explained to you

- Does the patient need to be pre-medicated with an antibiotic for any dental procedures? Yes No

MEDICATIONS
List medications you are currently taking: _____
Pharmacy Name: _____
Pharmacy Phone: _____

ALLERGIES
<input type="checkbox"/> Latex <input type="checkbox"/> Food (please list) _____
<input type="checkbox"/> Nickel <input type="checkbox"/> Other _____
<input type="checkbox"/> Mint

Parent's/Patient's Signature _____	Date _____
Doctor's Signature _____	Date _____